TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
CRS MCKEESPORT

Respondent Name
GENERAL MOTORS CORP.
(SELF-INSURED)

MFDR Tracking Number
M4-17-3092-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
June 19, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Sedgwick approved payment to [the provider] for October 2016, without authorization. Benefits were verified on 9/29/2016 . . . with Tom and was told authorization was not required. Please see attached 'Initial Business Intake Form'."

Amount in Dispute: $1,589.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor chose to accept the Claimant knowing his [sic] treatment was covered under Texas workers' compensation. Requestor, by accepting this patient, is bound by the Texas Labor Code and the corresponding rules. Therefore, the denial of the services should be upheld."

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 3, 2016 to December 19, 2016	Physical Therapy Services	$1,589.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out rules regarding preauthorization of health care.
3. Texas Labor Code §413.031 entitles health care providers to a review of services if payment is denied.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 197 – PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION.

Issues

1. Under what authority is this request for medical fee dispute resolution considered?
2. Has the respondent supported denial of payment for lack of preauthorization?

Findings

1. The requestor is a health care provider that rendered disputed services in the state of Pennsylvania to an injured employee subject to a Texas Workers' Compensation insurance claim. The health care provider has requested medical dispute resolution in accordance with Texas Labor Code Section 413.031(a)(1), which entitles a health care provider to a review of medical services if payment is reduced or denied. Because the requestor has sought the administrative remedy provided in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the Division concludes it has jurisdiction to decide the medical fee issues in this dispute pursuant to the Texas Workers' Compensation Act and applicable division rules.

2. The insurance carrier denied disputed services with claim adjustment reason code:

   - 197 – "PAYMENT DENIED/REDUCED FOR ABSENCE OF PRECERTIFICATION/AUTHORIZATION."

   Division Rule at 28 Texas Administrative Code §134.600(c)(1) requires the insurance carrier to be liable for all reasonable and necessary medical costs relating to the disputed health care listed in subsections (p) or (q) when the following situations occur:

   (A) an emergency, as defined in Chapter 133 . . .
   (B) preauthorization of any health care listed in subsection (p) . . . approved prior to providing the health care;

   Rule §134.600(p)(5) states that non-emergency health care requiring preauthorization includes:

   Physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:
   (A) Level I code range for Physical Medicine and Rehabilitation, but limited to:
      (i) Modalities, both supervised and constant attendance;
      (ii) Therapeutic procedures, excluding work hardening and work conditioning;
      (iii) Orthotics/Prosthetics Management;
      (iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code; and
   (B) Level II temporary code(s) for physical and occupational therapy services provided in a home setting;
   (C) except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following:
      (i) the date of injury; or
      (ii) a surgical intervention previously preauthorized by the insurance carrier;

   The disputed services constitute physical therapy modalities and therapeutic procedures falling within the HCPCS Level I code rage for physical medicine listed in Rule §134.600(p)(5)(A)(i) and (ii); the division therefore concludes that in the absence of an emergency, preauthorization was required for the disputed services by division rules. Review of the submitted information finds insufficient documentation to support an emergency or that the disputed services were preauthorized.

   The requestor further asserts that benefits were verified September 29, 2016 and that "Tom" with Sedgwick advised that authorization was not required, referring to an attached 'Initial Business Intake Form' as support. Review of the submitted information finds no 'Initial Business Intake Form' attached to support that the insurance carrier agreed to waive the preauthorization requirements.

   The requestor argues that Sedgwick approved payment to the provider for their October bill submission without authorization. This is supported by a copy of an explanation of benefits showing payment from Sedgwick for the October services. This fact is troubling, as it lends credence to the requestor's assertion that the adjustor may have initially advised that no authorization was required. However, without contemporaneous documentation to support what was discussed in that initial benefit verification conversation on September 29th, the requestor has failed to support the argument by a preponderance of the evidence.

The requestor did supply a "Guarantor Account Note Listing" detailing contacts and discussions with the insurance carrier. However, the notes did not include September 29, 2016 — or any information to support that the insurance carrier, or their agent, had waived any preauthorization requirements. On the contrary, the notes state that on February 13th a telephone message was left with "Tom Busbee," the Sedgwick adjustor responsible for the claim. He returned the call later that day, informing the clinic that "this injury occurred in Texas, authorization is required to treat the patient. These visits are not covered. No retro auth will be granted."

Based on the submitted information, the requestor has failed to support that the insurance carrier waived any preauthorization requirements. Accordingly, the insurance carrier's denial reason is supported. Additional reimbursement cannot be recommended.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The division would like to emphasize that the findings and decision in this dispute are based on the evidence presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the division finds that the requestor has failed to establish that additional reimbursement is due. As a result, the amount ordered is $0.00.

The division reminds the health care provider that, per Texas Labor Code §413.042 (regarding private claims):

(a) A health care provider may not pursue a private claim against a workers' compensation claimant for all or part of the cost of a health care service provided to the claimant by the provider unless:
  (1) the injury is finally adjudicated not compensable under this subtitle; or
  (2) the employee violates Section 408.022 relating to the selection of a doctor and the doctor did not know of the violation at the time the services were rendered.

(b) A health care provider commits an administrative violation if the provider violates Subsection (a).

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031, the division hereby determines the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	July 27, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.